

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/07/2011
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST MARGARET HEALTH - DYER			STREET ADDRESS, CITY, STATE, ZIP CODE 24 JOLIET ST DYER, IN 46311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of two state hospital complaints.</p> <p>Complaint Number: IN00085790</p> <p>Unsubstantiated: No deficiencies cited.</p> <p>Date: 9/7/11</p> <p>and</p> <p>Complaint Number: IN00094319</p> <p>Unsubstantiated: No deficiencies cited.</p> <p>Date: 9/7/11</p> <p>Facility Number: 005080</p> <p>Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor</p> <p>Franciscan St. Margaret Health is in compliance with 410 IAC 15-1.5-1, Dietetic services, 410 IAC 15-1.5-2, Infection control, 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing service, 410 IAC 15-1.5-8, Physical plant, and 410 IAC 15-1.6-5, Psychiatric services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 09/15/11</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1